

FORM **NNHS-5**  
(1-31-95)

U.S. DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
ACTING AS COLLECTING AGENT FOR THE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
U.S. PUBLIC HEALTH SERVICE  
CENTERS FOR DISEASE CONTROL AND PREVENTION  
NATIONAL CENTER FOR HEALTH STATISTICS

1995

**EXPENSE QUESTIONNAIRE**

**NATIONAL NURSING HOME SURVEY**

**NOTICE** – Public reporting burden of this collection of information is estimated to average 60 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PHS Reports Clearance Officer; ATTN: PRA (0920-0353); Hubert H. Humphrey Bldg., Rm. 737-F; 200 Independence Ave., SW; Washington, DC 20201. Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or the establishment in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

**Section A – AUTHORIZATION**

I hereby authorize \_\_\_\_\_ of \_\_\_\_\_  
(Accountant's name) (Accountant's address)

\_\_\_\_\_  
(Accountant's telephone number)

**to list for the most recently completed fiscal year the following financial data for this facility:**

\_\_\_\_\_  
(Date) (Signature) (Title)

**Section B – INSTRUCTIONS**

**PLEASE READ THESE INSTRUCTIONS CAREFULLY BEFORE YOU BEGIN TO ANSWER THE EXPENSE QUESTIONNAIRE.**

The definition booklet highlights the substance of each cost grouping, as well as related groupings of expense to be excluded from specific cost definitions. Since the intent of this questionnaire is to obtain information that is comparable among facilities, it is important that you read each of the definitions before answering the questions to which they apply.

The cost categories in the questionnaire are aimed at the total cost of care for patients. To capture all costs incident to providing health care in a home, those services and supplies specifically purchased for sale to patients should also be included in the relevant cost categories.

Since the financial data requested in this questionnaire are to be used with other survey information, it is necessary to provide data which have comparable time periods. Therefore, please give the financial data for the most recently completed fiscal year (calendar year or other 12 month period) and specify that time period in Section C on page 2 of this questionnaire. If for some reason, the twelve months of data are not available, specify in Section C the time period to which the data apply. The data may be reported on either a cash or accrual basis as long as there is consistency in the system applied throughout the entire period under report.

In general, it is essential that all recorded expenses incurred by the facility be included in the expense categories. Excluded from costs, however, are any losses sustained in the sale or disposition of fixed assets and other extraordinary losses not related to the current cost of providing health care.

**AFFILIATED FACILITIES:** If a nursing home is an affiliate of another facility, such as a retirement facility, the records on only the nursing home units should be used in this survey. Where the records of a home are part of the total accounting system, allocation techniques may be required to identify certain of the costs such as payroll, rent, supplies, and insurance. This is acceptable providing a sound basis is established for the allocation.

Section C – FISCAL YEAR

PLEASE LIST THE DATES OF THE FACILITY’S MOST RECENTLY COMPLETED FISCAL YEAR IN THE BOXES PROVIDED AND SUPPLY THE REQUESTED FINANCIAL DATA FOR THAT TIME PERIOD BELOW AND ON THE FOLLOWING PAGES.

Month	Year				

 TO 

Month	Year				

Section D – ACCOUNTING SYSTEM

IF YOUR ACCOUNTING SYSTEM DOES NOT GENERATE COST ITEMS AS CATEGORIZED BELOW AND ON THE FOLLOWING PAGES, PLEASE USE YOUR BEST ESTIMATE OF ALLOCATIONS AMONG THE LINE ITEMS.

ACCOUNTANT, PLEASE ROUND AMOUNTS TO THE NEAREST WHOLE DOLLAR.

Section E – EXPENSES AND REVENUES

EXPENSES		DOLLAR AMOUNTS
(Please refer to Definition Booklet)		
1. Payroll Expense (Do not include contract services);		If none, please enter "0".
a. Wages and Salaries (gross amount including employees' vacation and sick pay, taxes, etc.):		
(1) Nursing staff payroll expense (include RN's, LPN's, LVN's, aides, orderlies, student nurses, and other nursing staff)	1a. (1)	
(2) Physicians, other professionals and semi-professionals payroll expense (include only those employees who provide health care services)	1a. (2)	
(3) Dental staff payroll expense (including dentists, dental hygienists and other dental staff)	1a. (3)	
(4) All other staff payroll expense (all employees not listed in (1), (2), and (3), i.e., those <u>not</u> providing health care services)	1a. (4)	
(5) Subtotal of wages and salaries (add lines 1a(1), 1a(2), 1a(3), and 1a(4))	1a. (5)	
b. Payroll Taxes and Fringe Benefits (employer share of payroll taxes, state unemployment, group health and life insurance, and all other payroll and non-payroll benefits paid by employer)	1b.	
c. Total Payroll Expenses (add lines 1a(5) and 1b)	1c.	
2. Health Care Services purchased from outside sources:		
a. Nursing Services	2a.	
b. Dental Services	2b.	
c. Mental Health Care Services (Psychiatrists and other mental health care services)	2c.	
d. Other Health Care Services (Physicians, Therapists, Laboratory services, and other services that provide health care)	2d.	
e. Total expenses of Health Care Services purchased from Outside Sources (add lines 2a, 2b, 2c and 2d)	2e.	
3. Equipment Rent	3.	
4. Insurance (include professional public liability and other insurance)	4.	
5. Taxes and licenses (include franchise tax)	5.	
6. Interest and Financing Charges	6.	
7. Rent on Building and Land	7.	
8. Amortization of Leasehold Improvements	8.	
9. Depreciation Charges (Buildings and Equipment)	9.	
10. Food and other dietary items (include cost of services purchased from outside sources)	10.	
11. Drug Expenses (include cost of drugs purchased for patients and sold directly to them)	11.	

Section E – EXPENSES AND REVENUES

EXPENSES <i>(Please refer to Definition Booklet)</i>		DOLLAR AMOUNTS  <i>If none, please enter "0".</i>
12. <b>Supplies and Equipment</b> <i>(include cost of supplies and equipment purchased for patients and sold directly to them)</i>	12.	
13. <b>Purchased Maintenance of buildings, grounds and equipment</b>	13.	
14. <b>Purchased Laundry and Linen services</b>	14.	
15. <b>Utilities</b> <i>(telephone, gas, water and electricity)</i>	15.	
16. <b>Other and Miscellaneous Expense</b> <i>(include dues, subscriptions, travel, automobile, advertising, other services not included elsewhere, medical and non-medical fees, unclassified). See Section F below.</i>	16.	
17. <b>TOTAL EXPENSES</b> <i>(add expense category line items 1c, 2e and 3 through 16)</i>	17.	
REVENUES		
18. <b>Total Revenue:</b>		
A. <b>Patient Care Revenues</b> <i>(include all public and private payments for routine and ancillary health care services.)</i>		18A.
(1) Public Payments		
a. Medicaid	18A. (1a)	
b. Medicare	18A. (1b)	
c. All Other Public Payments – Specify <u>      </u>	18A. (1c)	
(2) Private Payments	18A. (2)	
B. <b>Non-patient Revenues</b> <i>(include all sources of non-patient revenues such as contributions for general operating purposes, payment for services not directly related to patient care, interest, dividends and capital gains.)</i>		18B.
C. <b>TOTAL REVENUES</b> <i>(add subtotal 18A and subtotal 18B)</i>		18C.

Section F – OTHER AND MISCELLANEOUS EXPENSES

If Other and Miscellaneous Expense (item 16) comprise 10 percent or more of the total expenses (item 17), please give details below of major amounts which constitute 20 percent or more of item 16.		AMOUNT
Description		
1.	1.	
2.	2.	
3.	3.	

PLEASE CHECK THE ADDITION OF ALL SUBTOTALS AND TOTALS

Section G – RESPONDENT

For the purposes of following up on any difficulties encountered in the analysis of this information, please record your name, phone number, your title (accountant, administrator, etc.), and the date you completed this questionnaire.

Name \_\_\_\_\_ Phone Number (\_\_\_\_) – \_\_\_\_\_

TITLE \_\_\_\_\_ COMPLETION DATE \_\_\_\_\_

THANK YOU FOR YOUR TIME AND COOPERATION IN FILLING OUT THIS QUESTIONNAIRE.  
PLEASE RETURN ONLY THE QUESTIONNAIRE IN THE ENCLOSED POSTAGE PAID ENVELOPE.  
YOU MAY THROW AWAY THE DEFINITION BOOKLET.